

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN9202</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - LIC</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/26/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>HILLVIEW COMMUNITY LIVING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>897 EVERGREEN STREET, PO BOX 769 DRESDEN, TN 38225</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies  This Rule is not met as evidenced by: During the investigation survey conducted on 9/26/12 this facility was found to be in compliance with the requirements of the National Fire Protection Association (NFPA) 101, Life Safety Code, 2000 edition, Chapter 19, Existing Health Care Occupancies.	N 002		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

JN1P21

If continuation sheet 1 of 1